The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Soldiers' Home in Holyoke
110 Cherry Street
Holyoke, MA 01040
(413) 532-9475

SOLDIERS' HOME IN HOLYOKE APPLICATION FOR LONG TERM CARE

DATE:_____

NAME:_____

CURRENT ADDRESS:_____

City/Town:_____ State:_____ Zip:_____

PHONE:_____

SOCIAL SECURITY #:_____

D.O.B:_____

DO YOU HAVE ANY SERVICE CONNECTED DISABILITIES?_____
IF YES, WHAT PERCENT?_____
WHAT FOR?:_____

YOU HAVE ANY INDUSTRIAL OR AUTOMOBILE ACCIDENT LITIGATION PENDING?_____

HAVE YOU EVER RECEIVED CARE AT THE SOLDIERS' HOME IN HOLYOKE?_____

WHERE IS THE VETERAN NOW?

Home:_____
Hospital:_____
Long Term Care Facility:_____
Date of admission into present facility:_____

LAST PRIVATE RESIDENCE:_____

CURRENT PHYSICIAN:_____

SOCIAL WORKER (IF PRESENTLY IN HOSPITAL OR NURSING HOME):_____

DIAGNOSES:

_____

PRIMARY CONTACT PERSON:

Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____
Home phone:_____ Work:_____ Other:_____
Relationship to veteran:_____

Is the primary contact person also the veterans'

(health care agent),(guardian) or (power of attorney)?

(Please circle all that apply.)

The names of the veteran's parents and their birth places – if known(even if they are deceased):

_____

_____

If the veteran has GI insurance, the amount it is for:_____
(Written proof is NOT necessary for this).

Has the veteran ever had any previous care at any VA facility?
If so, where and when?_____

Please circle: Inpatient Outpatient

What is the veteran's religious denomination (if any)?_____

What was the veteran's primary occupation?_____

What is the veteran's marital status?_____

Approximately how many years has the veteran lived in Massachusetts?_____

Who would you like to be the first contact person?

Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____
Phone: Home:_____ Work:_____ Other:_____
Relationship to the veteran:_____

Who would you like to be the second contact person?

Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____
Phone: Home:_____ Work:_____ Other:_____
Relationship to the veteran:_____

The third contact person (if any):

Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____
Phone: Home:_____ Work:_____ Other:_____
Relationship to the veteran:_____

To whom shall we send the room and board bill every month? (Guarantor)
Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____
Phone: Home:_____ Work:_____ Other:_____
Relationship to the veteran:_____